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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, A. D. 1941

No. 729

LINA H. HALVERSON, BENEFICIARY,
Petitioner,

vs.

THE UNITED STATES OF AMERICA,
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS FOR THE SEVENTH CIRCUIT AND BRIEF IN SUPPORT THEREOF.

JOSEPH J. WITRY,
Attorney for Petitioner.

FRANK A. MCCARTHY,
JOHN E. TOOMEY,
JAMES C. O'BRIEN, JR.,
Of Counsel.

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INDEX.

PAGE

PETITION:

I. Summary Statement of the Matters Involved 1
II. The Facts 2
III. Statutes Involved 7
IV. Decisions of the District Court and United States Court of Appeals 9
V. Questions Presented 10
VI. Reasons Relied on for Allowance of Writ 10

BRIEF IN SUPPORT OF PETITION:

I. Opinions of Courts Below 15
II. Jurisdiction 16
III. Statement of the Case 16
IV. Specification of Errors 16
V. Argument
A. The knowledge acquired by the Administrator through his officers and employees in the Hospitalization, Disability and Pension Divisions concerning insured's health constituted knowledge to him in the Insurance Division of his office 17
B. The Government is bound by the same rules of estoppel in war risk insurance contracts as private insurance companies 20
C. The Government is estopped from asserting that deceased insured was guilty of fraud in procuring the reinstatement of his insurance policy 21
D. Insured neither consulted nor was treated by physicians within the meaning of the policy of insurance 22

CONCLUSION 24

PAGE

CITATIONS.

Cases:

Atlantic Insurance Co. v. Stringer, (C. C. A.) 28 F. (2d) 665, 666 24

Combs v. Equitable Life Ins. Co., (C. C. A. 4th) 120 F. (2d) 432, 436 23

Cooke v. United States, 91 U. S. 389, 23 L. Ed. 237 21

Jeffress v. New York Life Ins. Co., (C. C. A. 4th) 74 F. (2d) 874 23

Jones v. United States, (C. C. A. 5th), 106 F. (2d) 888, 890 ..... 12, 18, 20

Knights of Pythias v. Kalinski, 163 U. S. 289, 298 22

Loveland v. United States, (D. C.) 18 F. (2d) 585; (C. C. A. 3rd) 25 F. (2d) 447; Certiorari Granted in 277 U. S. 583, 72 L. Ed. 999, 48 S. Ct. 603; Error confessed in 278 U. S. 665, 73 L. Ed. 571, 49 S. Ct. 80 11

Lynch v. United States, 292 U. S. 570, 580; 78 L. Ed. 1434, 1441; 54 S. Ct. 840 ..... 20, 21

Mutual Life Ins. Co. of New York v. Dobler, (C. C. A. 9th) 137 F. 550 23

New York Life Ins. Co. v. Eggleston, 96 U. S. 572, 24 L. Ed. 841 22

Phoenix Mutual Life Ins. Co. v. Raddin, 120 U. S. 183, 7 S. Ct. 500, 30 L. Ed. 644 ..... 21, 22

Ray v. United States, (C. C. A. 7th), 121 F. (2d) 416 12

Raives v. Raives, 54 F. (2d) 267 12

Ritter v. United States, (C. C. A. 3rd) 28 F. (2d) 265 18, 20

Schimp v. Cedar Rapids Insurance Co., 124 Ill. 354 22

Standard Oil v. United States, 267 U. S. 76, 79; 69 L. Ed. 519, 521, 45 S. Ct. Rep. 211 12

PAGE

CITATIONS.

Cases (continued):

Stipcich v. Metropolitan Life Ins. Co., 277 U. S. 311, 72 L. Ed. 895, 48, 49, S. Ct. 512 18

United States v. Chandler, (C. C. A. 6th) 29, 152 F. 25, 41 21

United States v. DePew, (C. C. A. 10th), 100 F. (2d) 725 12

United States v. Patryas, (C. C. A. 7th), 90 F. (2d) 715; Certiorari granted in 302 U. S. 676, 82 L. Ed. 883, 58 S. Ct. 142; Affirmed in 303 U. S. 341, 82 L. Ed. 883, 58 S. Ct. 551 ..... 11, 18, 20

United States v. Riggins, 65 F. (2d) 750 12

United States v. Stewart, 311 U. S. 60, 78 L. Ed. 25, 32 21

United States v. Walker, D. C. 139 F. 409, affirmed (C. C. A.) 148 F. 1022 21

United States v. Worley, 281 U. S. 339, 74 L. Ed. 887, 50 S. Ct. 291 11

Wilbur National Bank v. United States, 294 U. S. 120, 79 L. Ed. 798, 55 S. Ct. 362, 364 11

65 C. J. 1276, 1277 18

21 C. J. 1186 21

2 Couch on Insurance, Section 525, a-d, pages 525, 526, Section 889, pages 3018-20 ..... 18, 23

Statutes:

Section 310 of World War Veterans Act, 1924 as amended (U. S. C., Title 38, Section 512 (a)) 7, 20

Section 307 of World War Veterans Act, 1924, as amended (U. S. C., Title 38, Section 518) 7

Section 5 of World War Veterans Act, 1924, as amended, (U. S. C. Title 38, Section 426) 7, 20

PAGE

CITATIONS.

Statutes (continued):

Section 7 of World War Veterans Act, 1924, as amended, (U. S. C. Title 38, Section 430) 8
Section 240 of Judicial Code, (U. S. C. Title 28, Section 347) 16
Section 430 of World War Veterans Act, 1924, (U. S. C., Title 38, Section 430) 18
Section 10 of World War Veterans Act, 1924, (U. S. C. Title 38, Section 434 et seq.) 20

IN THE

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No.

LINA H. HALVERSON, BENEFICIARY,
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vs.

THE UNITED STATES OF AMERICA
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS FOR THE SEVENTH CIRCUIT.

To the Honorable Chief Justice and the Associate Justices of the Supreme Court of the United States:

Your petitioner, Lina H. Halverson respectfully prays that a writ of certiorari issue to review the judgment of the United States Circuit Court of Appeals for the Seventh Circuit rendered in the above case on the 25th day of June, 1941 (R. 101) reported in 121, F. (2d) 420.

I.

Summary Statement of the Matters Involved.

The petitioner, Lina H. Halverson, as beneficiary under a war risk insurance policy, instituted suit against the United States to recover the $10,000.00 death benefit contained in the policy. The evidence was heard without a

jury and the trial Court entered judgment against petitioner for costs (Rec. 81). On appeal to the United States Circuit Court of Appeals for the Seventh Circuit, the judgment of the Trial Court was affirmed. (R. 101). Petition for rehearing was denied August 4th, 1941. (R. 102).

II.

The Facts.

Harry M. Halverson, deceased insured, secured an honorable discharge from the military service of the United States in the year 1919. While in the service he was issued a Ten Thousand Dollar war risk insurance policy which lapsed for non-payment of premium on July 1, 1919. (Rec. 20.) On March 11, 1931, he signed an application to reinstate this policy. (Rec. 47.) He submitted to a medical examination at Hines, Illinois, and was pronounced a first class risk by Dr. A. L. Little, General Medical Examiner of the Veterans Administration. (Rec. 52.) In the application for insurance he was asked if he had ever been treated for any disease of the kidney or bladder and if he contracted any disease or consulted a physician in regard to his health since the date of his discharge. He answered "no." (Rec. 50.) The policy was issued on March 31, 1931. It contained a provision that it would be incontestable from the date it was issued except for fraud or non-payment of premiums. (Rec. 19.) Insured died on May 28, 1937. (Rec. 62.) All premiums were paid on the policy up to and including one month subsequent to insured's death. (Rec. 20.) The June 1937 premium not then due amounting to $22.90 was paid in advance by petitioner in May 1937. She later requested the return of this unearned premium, but it was not repaid. (Rec. 68, 75.) The total premiums paid by insured during the life of the policy, that is from March 31,

1931, to June 1937, were $796.40, no part of which has been repaid or tendered. (Rec. 75.) At the time insured applied for insurance he carried two other insurance policies with private companies on his life, one for $2,000.00 and the other for $2,500.00. After the issuance of this policy he dropped the other two policies. (Rec. 68.) After insured died petitioner, who was the beneficiary named in the policy, filed her claim for the death benefit. It was denied by the Director of Insurance on July 6, 1937, on the ground that insured made fraudulent statements in his application for insurance. (Rec. 74.) Her appeal from this decision was denied on September 15, 1937, and the claim was finally rejected by the Administrator of Veterans Affairs on February 4, 1938. (Rec. 20.) This suit was commenced on February 28, 1938. (Rec. 2.)

The evidence shows that on December 10, 1932, twenty months after the issuance of the policy herein sued upon, insured was examined by Dr. McDougal at Hines Hospital, a regional office of the Administrator of Veterans. (Rec. 29, 30.) This physician made an urology examination of insured and diagnosed his condition as pre-malignant cancer of the bladder. Insured gave a history to Dr. McDougal in 1932, that he first noticed blood in his urine three years prior to that time; he said that in 1930 a physician made a cystoscopic examination of the bladder and found a polypus growth, sometimes called a wart. (Rec. 30.) This history together with Dr. McDougal's diagnosis of insured's condition was then dictated into a dictaphone after which a stenographer transcribed seven copies, copies of which Dr. McDougal supposed were sent to various departments of the government, including Washington, and the Department of Justice. (Rec. 32.)

Dr. Martin R. Broman who made the cystoscopic examination of insured testified that he made the examination on September 20, 1930, and it was his recollection

that insured stated at that time that he first noticed blood in his urine a week before that date. He said a cystoscopic examination consists of inserting an instrument with lights into the bladder so that you can see if there are any abnormalities. He said he found a small growth on the posterior wall of the bladder, which is known as a wart-like growth. (Rec. 34.) That he told insured to return and he would cauterize it or burn it out. The physician said a papilloma is not considered serious but of course, should be investigated. He never saw insured after that time and he did not tell him that the growth was malignant or might become cancerous. He also said that in his opinion it was not cancerous at the time of that examination. (Rec. 36.)

There was also evidence that insured discussed his condition generally with a physician on two occasions. (Rec. 27.) Once in March, 1920, with a Dr. Bowe, who was then attending insured's wife at the birth of a baby. (Rec. 27.) Insured is supposed to have complained that he had some backaches since service in France and of pain and of frequent urination. (Rec. 27.) It was Dr. Bowe's recollection that he took his blood pressure and took a specimen of his urine and made a urinalysis in his office. (Rec. 27.) This was denied, however, by petitioner, and to rebut his testimony she testified that the conversation between insured and Dr. Bowe was very informal, that the doctor inquired how insured was feeling in a "kidding manner" and insured replied that he had a backache and the doctor told him to drink more water. (Rec. 65.) She denied that the doctor took his blood pressure or a sample of his urine. (Rec. 65.) Petitioner then offered in evidence an affidavit signed by Dr. Bowe (Plaintiff's Exhibit 2), which stated that the consultation and examination of insured on March 15, 1920, did not extend over a period of fifteen minutes and that insured's color was good, his general appearance as to health excellent

and that he did not tell him that he was in poor health and that he prescribed nothing more than diet and urolithia. (Rec. 29.) The second time that Dr. Bowe talked with insured regarding his health was on April 15, 1930, when he was treating insured's wife at her home for an acute cold. (Rec. 28.) The physician testified that insured complained of having passed blood in his urine occasionally since 1927, after exertion such as playing golf. (Rec. 28.) That he recommended that insured have a cystoscopic examination by some physician; that he did not have the type of an instrument for this purpose. He said that he did not consider this a consultation with insured. (Rec. 28.) On the other hand, petitioner showed that Dr. Bowe was treating her on April 15, 1930, for ptomaine poisoning and that before leaving the two men started to talk and she heard Dr. Bowe say: "How are you young fellow" and that her husband replied that he still had a backache and sometimes blood in his urine occasionally after playing golf. She heard Dr. Bowe say that this might come from anything but he suggested a cystoscopic examination. (Rec. 65.)

The undisputed evidence showed that outside of these so-called consultations with Dr. Bowe and the physical examination by Dr. Broman that insured never consulted a physician for any purpose whatsoever. He never complained of any illness and the first time his wife ever heard him mention blood in his urine was when he talked to Dr. Bowe in 1930; that thereafter he was examined by Dr. Broman and he seemed greatly relieved to find out it was just a wart and could be burned out at any time. (Rec. 66.) She said he seemed to have forgotten the incident entirely after that time.

The undisputed evidence shows that respondent was told of these so-called consultations with physicians on December 10, 1932, at the time insured gave his history

to Dr. McDougal. (R. 30.) The respondent was again apprised of the same matters on February 6, 1933, when insured filed a written application for compensation for disability in the world war. (Rec. 53.) In this application for disability he was asked to give the names and addresses of all civilian physicians who had treated him for any sickness, disease or injury since the beginning of service in the world war and he mentioned Dr. Bowe and Dr. Broman. (Rec. 53.) In this same application he was also asked if he ever applied for war risk insurance and he replied that he had. (Rec. 54.) Various letters thereafter were sent to him in connection with the application for disability and in some of these letters commencing as early as May 7, 1936, reference was had to evidence from Drs. Bowe and Broman. (Rec. 69, 70, 71, 72, 73). The record also shows that on each occasion that insured went to United States Veterans Hospital at Hines, Illinois, which occurred in 1933, 1935 and 1937, a history was taken from him in which he mentioned the first occasion when he passed blood in his urine and his cystoscopic examination. (Rec. 58, 60, 61, 62.) The result of these examinations, containing also the history of the patient and the various admissions, were typed, subscribed to by the Chairman and two members of the Board at Hines Hospital and by the Medical Officer and Associate Medical Officer.

Principal cause of insured's death was carcinoma of the bladder (Malignant) and the contributory cause of importance was Hydronephrosis, right Bronchopneumonia. (Rec. 21.)

III.

Statutes Involved.

Section 310 of the World War Veterans Act, 1924, as amended (U.S.C., Title 38, Section 512 (a), provides in part:

> Notwithstanding the provisions of sections 511 and 512 of this title, the United States, upon application to the Veterans' Administration, shall grant United States Government life (converted) insurance against death or permanent total disability in any multiple of $500. and not less than $1,000 or more than $10,000 to any person who had prior to May 29, 1928, applied or been eligible to apply for yearly renewable term insurance or United States Government life (converted) insurance: *Provided,* That such person is in good health and furnishes evidence satisfactory to the Administrator of Veterans' Affairs to this effect: *Provided further,* That no person may carry more than $10,000 of United States Government life insurance at one time: * * *

Section 307 of the same Act as amended (U.S.C., Title 38 Section 518) provides:

> All contracts or policies of insurance heretofore or hereafter issued, reinstated, or converted shall be incontestable from the date of issuance, reinstatement, or conversion, except for fraud, nonpayment of premiums, or on the ground that the applicant was not a member of the military or naval forces of the United States, and subject to the provisions of section 447 of this title: * * *

Section 5 as amended (U.S.C. Title 38 Section 426) provides:

> "The Administrator of Veterans' Affairs, subject to the general direction of the President, shall admin-

ister, execute, and enforce the provisions of this chapter, and for that purpose shall have full power and authority to make rules and regulations, not inconsistent with the provisions of this chapter, which are necessary or appropriate to carry out its purposes, and shall decide all questions arising under this chapter; and all decisions of questions of fact and law affecting any claimant to the benefits of Part II or III of this chapter shall be conclusive except as otherwise provided herein. All officers and employees of the Veterans' Administration shall perform such duties as may be assigned them by the Administrator. All official acts performed by such officers or employees specially designated therefor by the Administrator shall have the same force and effect as though performed by the Administrator in person. * * *''

Section 7 as amended (U.S.C. Title 38, Section 430), also provides:

"The Administrator of Veterans' Affairs shall establish a central office in the District of Columbia, and such regional offices and suboffices, not exceeding one hundred in number, within the territory of the United States and its outlying possessions as may be deemed necessary by him and in the best interests of the work committed to the Veterans' Administration and to carry out the purposes of this chapter. Such regional offices and suboffices may, subject to final action by the Administrator in case of an appeal, and under such rules and regulations as may be prescribed by the Administrator, exercise such powers for hearing complaints and for examining, rating, and awarding compensation claims, granting medical, surgical, dental, and hospital care, convalescent care, and necessary and reasonable after care, granting vocational training

and all other matters delegated to them or some of them, by the Administrator as could be performed lawfully under this chapter by the central office. * * *"

IV.

Decisions of the District Court and United States Court of Appeals.

1. The District Court found that insured made false and fraudulent misrepresentations and concealments in his application to reinstate his policy of insurance and that the Government was not estopped from contesting the policy on the grounds of fraud even though it collected premiums for some time after it received notice of the facts upon which the defense of fraud was based (R. 80, 81).

The Circuit Court of Appeals affirmed the District Court (R. 96, 101) opinion reported in 121 F. (2d) 420, and held that insured made fraudulent answers in his application for insurance and that the Government was not estopped from contesting the policy on this ground even though it accepted premiums after it received notice of the facts constituting the fraud for the reason that the facts were not made known to the Insurance Division of the Administrator's office but to the Compensation and Disability Division, and that the Administrator was not bound by the knowledge acquired by other divisions within his own office (R. 96, 101).

V.

Questions Presented.

1. Is the Veterans' Administration bound by the knowledge acquired by its officers and employees within the scope of their authority in dealing with veterans on war risk insurance policies?

(a) Can the Administrator divide his office into Divisions such as Hospitalization, Disability and Insurance, and then deny that he had knowledge of certain facts in the Insurance Division although admitting that he had knowledge in his other two capacities?

2. In the issuance of war risk insurance contracts is the Government of the United States bound by the same rules in the conduct of its business as private insurance companies?

3. Does not the continued acceptance of premiums for a period of at least five years after the Administrator acquired notice that certain answers in insured's application for insurance were untrue estop the Government from contesting the policy on the ground of fraud?

4. Does a casual discussion of a person's health with a physician on two occasions ten years apart and an examination by another physician constitute consultation and treatment within the meaning of a policy of insurance?

VI.

Reasons Relied On for Allowance of Writ.

Petitioner believes that the writ of certiorari should be granted because:

(a) The Circuit Court of Appeals has decided an important question of Federal law dealing with war risk in-

surance contracts issued by the Government of the United States under authority of an Act of Congress. (Section 310 of the World War Veterans' Act, 1924, as amended, U.S.C. Title 38, Section 512 (a).) The question of whether the Government is bound by the same rules in the conduct of this business as private insurance companies has not been passed on by this Court. Your Honors have heretofore recognized the importance of the question and granted certiorari in two cases, (*Wilbur National Bank* v. *United States,* 294 U. S. 120, 79 L. Ed. 798, 55 S. Ct. 362, 364; and *Loveland* v. *United States,* 277 U. S. 583, 72 L. Ed. 999, 48 S. Ct. 603), and in another instance the question was certified to this Court for decision. (*United States* v. *Worley,* 281 U. S. 339, 74 L. Ed. 887, 50 S. Ct. 291.) In the case last cited, *United States* v. *Worley,* 281 U. S. 339, 74 L. Ed. 887, 50 S. Ct. 291, this Court refused to pass on this feature of the case although it was argued in the briefs, because your Honors believed it unnecessary for a correct decision on the facts presented. Then in *Wilbur National Bank* v. *United States,* 294 U. S. 120, 79 L. Ed. 798, 55 S. Ct. 362, 364, this Court avoided passing on this point because the grounds usually relied upon for an estoppel did not exist. Later in *Loveland* v. *U. S.* (C.C.A. 3rd) 25 F. (2d) 447, reversing D.C. 18 F. (2d) 585, certiorari granted, 277 U. S. 583, 72 L. Ed. 999, 48 S. Ct. 603, the question was squarely presented on the decision of the Circuit Court of Appeals of the Third Circuit in holding that the Government was not estopped under a war risk insurance contract by the conduct of the officers and employees of the Veterans Administration in writing to the veteran and leading him to believe that his policy of insurance was in force. However, the Government then confessed error because of the failure to file a waiver of a jury trial before the case was decided by this Court. (*Loveland* v. *United States,* 278 U. S. 665, 73 L. Ed. 571, 49 S. Ct. 80.) More recently in *United States* v. *Patryas,* 90 F. (2d) 715, the

Circuit Court of Appeals of the Seventh Circuit held that the Government was estopped under the facts presented from refusing to pay a veteran's claim under a war risk contract, but the opinion stated that there was no fraud involved in the case. Certiorari was granted by this Court, (302 U. S. 676, 82 L. Ed. 522, 58 S. Ct. 142), and judgment was affirmed in 303 U. S. 341, 82 L. Ed. 883, 58 S. Ct. 551, but the question of whether the Government might be estopped by its conduct was not mentioned in the opinion of this Court.

This question is also of tremendous importance in view of the increasing number of instances where the Administrator defeats recovery on war risk insurance contracts by merely referring to the files in his own office in order to show that the insured veteran made fraudulent answers in his application for insurance. Information given by a veteran while he is receiving hospitalization or asking for disability compensation is carefully preserved and used after the veteran's death to deny payment on his policy to the beneficiary. In the meantime, the Administrator continues to accept premiums and does not disclose that the policy will not be paid upon the veteran's death. (*Ray* v. *United States,* (C.C.A. 7th), 121 F. (2d) 416; *United States* v. *DePew* (C.C.A. 10th), 100 F. (2d) 725; *Jones* v. *United States* (C.C.A. 5th), 106 F. (2d) 888; *United States* v. *Riggins,* 65 F. (2d) 750; *Raives* v. *Raives,* 54 F. (2d) 267.) In the present state of the law a veteran has no assurance that despite the years his policy is in force that his widow's claim to the death benefit may not be defeated for something he may have innocently divulged on a periodical medical check-up at a regional hospital of the Government.

Petitioner believes also that the decision of the Circuit Court of Appeals in this case is contrary to the opinion of this Court in *Standard Oil* v. *United States,* 267 U. S.

76, 79; 69 L. Ed. 519, 521; 45 S. Ct. 211, where the Court held in a war risk admiralty insurance case that when the United States went into the insurance business it must be assumed to have accepted the ordinary incidents of such suits in such business.

This is the first application for a writ of certiorari in this case.

WHEREFORE, it is respectfully prayed that the petition for Writ of Certiorari be granted.

Respectfully submitted,

LINA H. HALVERSON, *Petitioner,*

.....

By JOSEPH J. WITRY,
Attorney for Petitioner.

Of Counsel:
FRANK A. McCARTHY,
JOHN E. TOOMEY,
JAMES C. O'BRIEN, JR.

State of Illinois }
County of Cook } ss.

Joseph J. Witry, being first duly sworn, makes oath and says that he is the attorney for the petitioner in the above cause, and that he has prepared the foregoing petition, and that the allegations therein are true as he verily believes.

.....

Subscribed and Sworn to before me this ..... day of October, A. D. 1941.

.....
Notary Public.

In my opinion the foregoing petition is well founded in law.

.....

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, A. D. 1941

No.

LINA H. HALVERSON, BENEFICIARY,
Petitioner,

vs.

THE UNITED STATES OF AMERICA
Respondent.

BRIEF IN SUPPORT OF PETITION.

I.

OPINIONS OF COURTS BELOW.

The findings of fact, conclusions of law, and judgment of the United States District Court are set out in the record at pages 79, 80, 81 and 82, and the proposed findings of fact and conclusions of law submitted by petitioner are contained on pages 75, 76, 77, and 78, neither of which are reported. The opinion of the United States Circuit Court of Appeals for the Seventh Circuit is found in the record at pages 96, 97, 98, 99, 100, and 101, and is reported in 121 F. (2d) 420.

II.

JURISDICTION.

The jurisdiction of this Court is invoked to review the cause by writ of certiorari under Section 240 of the Judicial Code, U. S. C. Title 28, Section 347, providing for the granting of a writ of certiorari by this Court to review a final judgment or decree of the United States Circuit Court of Appeals.

III.

STATEMENT OF THE CASE.

A statement of the case is set out in the foregoing petition under the caption "Summary Statement of the Matters Involved", and "The Facts", to which reference is here made.

IV.

SPECIFICATION OF ERRORS.

1. The Circuit Court of Appeals erred in holding that the United States Government was not estopped from contesting the policy on the grounds of fraud.
2. The Circuit Court of Appeals erred in holding that notice of certain facts to the Compensation, Disability, Hospitalization and Pension Division of the Veterans Administration was not notice to the Insurance Division of the same office.
3. The Circuit Court of Appeals erred in holding that insured consulted and was treated by physicians within the meaning of the policy of insurance.

V.

ARGUMENT.

A.

The knowledge acquired by the Administrator through his officers and employees in the Hospitalization, Disability and Pension Division concerning insured's health constituted knowledge to him in the Insurance Division of his office.

The Circuit Court of Appeals held that the acceptance of premiums by the Administrator did not estop the Government from asserting the defense of fraud to a suit on the policy of insurance (R. 99). The opinion reasoned that although the Compensation Division of the Veterans Administration knew many years before insured's death that he was not in good health at the time of his reinstatement, that fact may not be used to estop the Insurance Division from canceling the policy (R. 100).

At the outset we desire to point out that the Insurance Division never canceled insured's policy of insurance. It merely refused to pay when death occurred (R. 74, 75).

The knowledge that the Administrator acquired of insured's death was shown by official reports and letters of the Administrator's officers and employees originating from treatment at the Veterans Administration Hospital at Hines, Illinois, and from applications to the Compensation and Pension Divisions of the office of the Administrator (R. 53, 63, 69, 74). The Circuit Court of Appeals held that because the Administrator separated his office into Compensation and Insurance Divisions, that facts within the knowledge of the Compensation Division could not be attributed to the Insurance Division (R. 96, 100).

The Act creating the office of Administrator of Veterans provides that

> "All official acts performed by such officers or employees specifically designated therefor by the Administrator shall have the same force and effect as though performed by the Administrator in person" (U.S.C. Title 38, Section 426).

Section 430 of the same Act, (U.S.C., Title 38 Section 430), provides for the creation of a central office in Washington, D. C. and regional offices throughout the United States and its possessions, and provides further that such regional offices should have the same powers and authority as the central office, subject to review by the Administrator.

Consequently, the knowledge that the officers and agents of the Administrator acquired in their official capacity as well as the documentary information on file in the Administrator's own office, should be held to be knowledge of the Administrator. (*Ritter* v. *United States*, (C.C.A. 3rd) 28 F. (2d) 265-267; 65 Corpus Juris, 1277; *Jones* v. *United States* (C.C.A. 5th) 106 F. (2d) 888, 890; *United States* v. *Patryas*, (C.C.A. 7th) 90 F. (2d) 715, 717, Affirmed in 303 U. S. 341, 82 L. ed. 883, 58 S. Ct. 551.)

Obviously there must be some separation of the duties of the Administrator's office for the orderly transaction of business but in this respect the government is no different than private insurance companies, whose mammoth size also requires just as strict a separation of its business into departments and inner departments. However, it is held that notice of facts which come to the attention of any one department, however minor, constitutes notice to the company. (2 Couch on Insurance, Sections 525a-d, pages 525, 526 and cases therein cited.) (*Stipcich* v. *Metropolitan Life Insurance Co.*, 277 U. S. 311, 72 L. Ed. 895, 48 S. Ct. 512.) We feel that in the present case

that there is an even more urgent reason for the application of this rule because despite the so-called separation of the business of the Compensation and Insurance Divisions, still in the application that insured filed with the Compensation Division for assistance he was asked if he carried war risk insurance. Insured answered that he did (R. 53, 54). This was filed on February 6, 1933, and there is no sufficient reason advanced why this question should be asked by the Compensation Division if there was no connection with the Insurance Division.

There is the further fact in the present case that the Insurance Division itself also had knowledge of the facts constituting the alleged fraud as the record shows that on May 13, 1937, insured filed an application with the Insurance Division claiming insurance benefits for total permanent disability (R. 57). In the application he declared that he had discussed his condition with physicians prior to the date he applied for insurance (R. 57). Thus even the Insurance Division had notice of all the facts prior to insured's death.

The Circuit Court of Appeals summarily disposed of this feature by stating that "The application for insurance benefits was not made out until a short time before Halverson's death, and the date of its receipt by the Insurance Division is not shown" (R. 100).

It is true that the application was made only fifteen days before insured died and the record shows that it was dated and acknowledged at the Veterans Administration as of that date, and the original application received in evidence as Defendant's Exhibit 9 bears the stamp of the Veterans Administration as of May 13, 1937 (R. 57). This should be sufficient identification of the date it was received at the Veterans Administration but if further proof is required this Court has the right under Rule 75 (h) and

(i) of Rules of Civil Procedure to require the original document to be sent up for examination.

We, therefore, respectfully submit that coupled with the other information in the Veterans Administration the notice to the Insurance Division of the Veterans Administration fifteen days before insured's death constituted sufficient and reasonable notice to the Administrator. (U.S.C. Title 38 Sec. 426.) (*United States* v. *Patryas* (C.C.A. 7th) 90 F. (2d) 715, 717; *Ritter* v. *United States,* (C.C.A. 3rd) 28 F. (2d) 265, 267; *Jones* v. *United States* (C.C.A. 5th), 106 F. (2d) 888, 890.)

B.

The Government is bound by the same rules of estoppel in war risk insurance contracts as private insurance companies.

The Act creating the office of Veterans Administration provides for the allowance of pensions, compensation allowances, gratuities, hospitalization, education, and many other benefits. (U.S.C. Title 38, Section 434, *et seq.*) It also provides for the issuance of war risk insurance contracts, the form of which is almost identical to that customarily used by private insurance companies. (U.S.C. Title 38, Section 512(a).) These policies of insurance it has been held by this Court are valid contracts of the United States and carry with them the legal obligations and incidents of the same dignity as other contracts of the United States. The beneficiaries enjoy the same rights and benefits as beneficiaries under policies of insurance issued by private corporations. (*Lynch* v. *United States,* 292 U. S. 571, 78 L. ed. 1434, 54 S. Ct. 850.)

Consequently, the Government of the United States should be bound by the same rules as those governing private corporations, and it should not be permitted to perpetrate upon its policy holders wrongs which it would

not tolerate if practiced by a private insurance company. (*Cooke* v. *United States,* 91 U. S. 389, 23 L. Ed. 237; *United States* v. *Chandler,* 152 F. 25, 41 (C.C.A. 6th) 29; *Lynch* v. *United States,* 292 U. S. 570, 580, 78 L. Ed. 1434, 1441, 54 S. Ct. 840, 21 C. J. 1186, 65 C. J. 1276; *United States* v. *Walker,* D. C. 139 F. 409, affirmed C.C.A. 148 F. 1022; *United States* v. *Stewart,* 311 U. S. 60, 78 L. Ed. 25, 32.)

C.

The Government is estopped from asserting that deceased insured was guilty of fraud in procuring the reinstatement of his insurance policy.

Insured died on May 28, 1937 (R. 20). The policy had been in effect over six years, during which time the Government collected nearly $800.00 in monthly premiums (R. 168). The Administrator neither returned nor offered to return any part of these premiums (R. 75). The payment for the month of June 1937 amounted to $20.90 which petitioner paid during May 1937, was also retained (R. 75). After insured's death petitioner wrote the Administrator stating that her husband died during May and requested the return of this unearned premium (R. 75). The Administrator replied that he would look into the matter but she heard nothing from him (R. 75).

The retention of the June 1937 premium alone, we think, is sufficient to estop the defendant from contesting the validity of the policy. The Administrator certainly knew after insured's death whether he intended to honor insured's contract and consequently, was thus obliged to either return the premium or acknowledge liability under the policy. (*Phoenix Mutual Life Ins. Co.* v. *Raddin,* 120 U. S. 183, 7 Sup. Ct. 500, 30 L. Ed. 644.) The record discloses that the Administrator first became apprised of insured's health on December 10, 1932, and he still collected premiums on this policy of insurance for nearly

five years thereafter. This is sufficient to work an estoppel, as the law will not permit the insurer to treat the policy in effect only for the purpose of paying premiums and then to later refuse to bear its burden. (*New York Life Ins. Co.* v. *Eggleston*, 96 U. S. 572, 24 L. Ed. 841; *Phoenix Mutual Life Ins. Co.* v. *Raddin*, 120 U. S. 183, 7 S. Ct. 500, 30 L. Ed. 644; *Knights of Pythias* v. *Kalinski*, 163 U. S. 289, 298; *Schimp* v. *Cedar Rapids Insurance Co.*, 124 Ill. 354.)

D.

Insured neither consulted nor was treated by physicians within the meaning of the policy of insurance.

In the application for the insurance policy herein sued on deceased insured was asked if he ever had been treated for any disease of the kidney or bladder and he answered "No" (R. 50). He was then asked the following question "Have you been ill, or contracted any disease, or suffered any injury or been prevented by reason of ill health from attending your usual occupation, or consulted a physician in regard to your health, since the date of discharge? Answer yes or no." Insured answered this series of questions "No" (R. 50).

The trial court found that deceased insured was treated for disease of the kidney or bladder and also consulted physicians in regard to his health since date of discharge (R. 80, 81).

The Circuit Court of Appeals agreed stating that insured discussed his condition more or less casually with the family physician twice and was afterwards examined by another doctor to ascertain what was troubling him. This the court held was more than a mere routine examination and although the result of the examination was reassuring it did not excuse him from disclosing it in his application (R. 96, 99).

The evidence offered by the government in support of its affirmative defense as revealed by the records of the Veterans Administration showed that in 1920 insured talked with the family physician who was attending insured's wife at the time of the birth of their baby and is supposed to have complained of backache and frequent urination since service in France (R. 65). Ten years later in 1930 insured again talked with this same physician when he was attending insured's wife for ptomaine poisoning and is reported to have told the Doctor of blood in his urine. The Doctor stated he did not diagnose insured's condition "because it really was not a consultation, just a casual visit to his wife" (R. 65, 28). The third and last alleged consultation or treatment occurred September 22nd, 1930, when a Dr. Broman made a cystoscopic examination of the bladder and found a small wart like growth and told insured to return and he would cauterize it, meaning he would burn it out (R. 33, 66). The fact that Dr. Broman said it was a wart and could be burned out anytime made insured treat the matter lightly and he never returned (R. 66).

It is perfectly obvious that insured was not *treated* by either physician. (See Couch on Insurance, Sec. 889, pages 3018-20); *Jeffress* v. *New York Life Insurance Co.* (C.C.A. 4th) 74 F. (2d) 874. Whether he consulted one is of course another matter. The two informal chats insured had with his family physician ten years apart can hardly be said to be a consultation because he did not retain the Doctor but merely visited with him while he was attending his wife (R. 65, 28). Surely this is not a consultation within the meaning of the policy. (*Mutual Life Insurance Co. of New York* v. *Dobler,* (C.C.A. 9th) 137 F. 550; *Combs* v. *Equitable Life Insurance Compay* (C.C.A. 4th) 120 F. (2d) 432, 436. That he was examined in 1930 by Dr. Broman is admitted but we respectfully submit that this one isolated visit to a doctor merely for an examination,

the result of which he took very lightly, should not be held to be an examination within the meaning of the policy of insurance. (*Atlantic Insurance Co.* v. *Stringer,* (C.C.A.) 28 F. (2d) 665, 666.)

CONCLUSION.

It is believed that the foregoing discussion and citation of authorities demonstrates that the decision of the Court below is erroneous. It is earnestly urged in the interest of all world war veterans who are constantly paying premiums for insurance that the right of the Administrator of Veterans Affairs to use certain facts in his own files in order to defeat recovery on policies of insurance but to deny knowledge of these same facts for all other purposes be fully and completely determined. It is, therefore, respectfully submitted in the light of the reasons indicated, that the petition should be granted.

.....

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III

I

INDEX

	Page
Opinions below	1
Jurisdiction	1
Questions presented	2
Statement	2
Argument	7
Conclusion	14

CITATIONS

Cases:

Bavisotto v. *United States*, 18 F. Supp. 355 — 11

Jones v. *United States*, 106 F. (2d) 888 — 10

Ritter v. *United States*, 28 F. (2d) 265 — 11

United States v. *Depew*, 100 F. (2d) 725 — 11

United States v. *Riggins*, 65 F. (2d) 750 — 11

Statutes:

Act of June 7, 1924, c. 320, 43 Stat. 615–628, Titles II, III, IV — 8

Act of June 7, 1924, 43 Stat. 615–628, as amended by the Act of July 3, 1930:

Sec. 1 (c. 863, 46 Stat. 1016; 38 U. S. C. Sec. 11) — 8, 9

Sec. 5 (c. 849, 46 Stat. 991; c. 863, 46 Stat. 1016, 38 U. S. C. Sec. 426) — 8, 9

Miscellaneous:

Federal Rules of Civil Procedure for the District Courts of the United States, Rule 52 (a) — 12

430649—41

In the Supreme Court of the United States

OCTOBER TERM, 1941

No. 729

LINA H. HALVERSON, PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINIONS BELOW

The District Court of the United States for the Northern District of Illinois rendered no opinion. Its findings of facts and conclusions of law appear at R. 80–81. The opinion of the Circuit Court of Appeals for the Seventh Circuit (R. 96–101) is reported in 121 F. (2d) 420.

JURISDICTION

The judgment of the Circuit Court of Appeals was entered on June 25, 1941 (R. 101), and a petition for rehearing was denied on August 4, 1941 (R. 102). The petition for a writ of cer-

tiorari was filed November 4, 1941. The jurisdiction of this Court is invoked under Section 240 (a) of the Judicial Code, as amended by the Act of February 13, 1925.

QUESTIONS PRESENTED

In a suit on an insurance policy the Government defended on the ground of fraud in its procurement. Petitioner alleged that the Government was estopped to assert the fraud.

The questions presented are:

1. Whether there is any basis for estoppel.

2. Whether the findings of the District Court that the insurance policy was obtained by fraud are clearly erroneous.

STATEMENT

Petitioner seeks to recover the proceeds of a $10,000 policy of United States Government life insurance issued to Harry Melvin Halverson on his application dated March 11, 1931 (R. 2–5). In its answer in the District Court, the Government asserted the single defense that the policy was obtained by fraud in that, in the application for it, the insured answered falsely and fraudulently certain questions, material to the risk, regarding his health (R. 9–11). Petitioner denied that the insured had answered either falsely or fraudulently, and alleged that, in any event, the Government was estopped to assert the defense of fraud because it had accepted premiums after

February 1933, when the Compensation Division of the Veterans' Administration received true information regarding the matters alleged to have been misrepresented by the insured (R. 13–14).

By consent of the parties, the case was submitted to the court for trial, without a jury (R. 16). Uncontradicted evidence tended to show the following:

In his application for the policy, executed on March 11, 1931 (R. 47–50), the insured represented as true, to the best of his knowledge and belief, that he had never been treated for any disease of the kidneys or bladder, and had not consulted a physician in regard to his health since the date of his discharge from the military service in 1919 (R. 50).

At least as early as April 1930, the insured had observed blood in his urine (R. 27, 30, 65), and had reported this fact to Dr. Bowe, who advised him to have a cystoscopic examination (R. 27, 65). Insured sought and obtained such an examination from Dr. Broman in September 1930. He complained of blood in his urine and the examination revealed that a wart-like growth inside his bladder was the source of it (R. 33–34, 65–66). The growth appeared not to be malignant at that time and, in the opinion of Dr. Broman, the condition could have been cured by cauterization. His advice to the insured to return for such treatment was not followed (R. 34, 66).

Upon a medical examination in June 1931, sought by the insured, blood was again found in his urine and hospital care was advised (R. 46). His condition was diagnosed as cancer in December 1932, and remained essentially stationary for a number of years, but finally became very malignant, causing his death on May 28, 1937 (R. 30–31, 60–64).

The insured discussed his condition with Dr. Bowe as early as 1920 but the petitioner, in her testimony, characterized that discussion, as well as the one referred to above when, in 1930, the same doctor advised a cystoscopic examination, as mere friendly conversations and not consultations in regard to his health (R. 65). Dr. Bowe testified that he made an examination of the insured on each of those occasions, which included at least the taking of his blood pressure and a urinalysis; that in 1920 the insured complained of having inflammation and pain of the bladder; that in 1930 he stated that he had observed blood in his urine; that in 1920 the diagnosis was guarded cystitis, acute inflammation of the bladder; and that although no diagnosis was made in 1930, a cystoscopic examination was advised because of a suspicion that there was some form of bleeding from the bladder (R. 27).

The petitioner testified, in effect, that after the cystoscopic examination in September 1930, the insured felt that his condition was not serious,

and no longer manifested uneasiness about it. Without reference to the medical examination of the insured in June 1931, which disclosed the presence of blood in his urine, she expressed the view that he forgot about his condition entirely from September 1930 to December 1932 (R. 66).

In support of his claims for compensation filed in the Veterans' Administration in February 1933 and April 1936, the insured stated that he was suffering from kidney and bladder trouble which began about February 1920, and that he had been treated for it by Dr. Bowe in 1920 and 1930, and by Dr. Broman in 1930 (R. 53–56). He made a similar recitation in an application for disability benefits under his insurance policy filed in the Veterans' Administration about May 13, 1937 (R. 57). In a letter dated July 6, 1937, the Director of Insurance of the Veterans' Administration advised the petitioner that the case had been reviewed and a determination made that the insured had made fraudulent statements in his application for insurance and that, accordingly, the proceeds of the policy could not be paid (R. 74–75).

Richard B. Posey, technical adviser on insurance in the Veterans' Administration, testified in effect, that since about 1920 insurance and compensation have been administered by separate divisions within the Veterans' Administration under such circumstances that information known

to the officials of one division, or contained in its files, would not in ordinary course reach the files or officials of the other division unless specifically requested. The question on the compensation application, "Did you ever apply for War Risk Insurance?" (R. 54), had its origin, this witness testified, prior to 1920, when insurance and compensation were handled by one division, and it had been retained because it had proved useful as a means of identifying the veteran on whose behalf claim was asserted (R. 43–44).

The court's findings of fact included findings that, in his application for the policy, the insured falsely and fraudulently, with the intent to mislead and defraud the Government, represented that he had never been treated for any disease of the kidneys or bladder, and that he had not consulted a physician in regard to his health since his discharge ~~disability~~ from the military service in 1919; that the misrepresentations and concealments were material to the issuance of the policy (R. 80). The court concluded that the policy was void because it had been procured fraudulently, and that the Government was not estopped to assert the fraud (R. 81).

From the judgment for the Government, entered in accordance with the court's findings of fact and conclusions of law (R. 81–82), petitioner appealed to the Circuit Court of Appeals for the Seventh Circuit. That court affirmed the

judgment of the District Court, pointing out in its opinion that the evidence was sufficient to warrant the findings of the District Court, and holding that the Government was not estopped to assert the defense of fraud (R. 96–101).

With respect to estoppel, the Circuit Court of Appeals held, in effect, that knowledge of facts revealed to the Compensation Division of the Veterans' Administration concerning the insured's treatment and consultation with doctors cannot be imputed to the Insurance Division, and that there was no duty on the part of the Insurance Division to examine the records, other than those of that Division, to ascertain whether the representations made by the insured, in his application for insurance, were true or false (R. 100).[1]

ARGUMENT

I

(a) The contentions advanced by petitioner concede, in effect, both that estoppel would not flow from the continued receipt of premiums in the absence of knowledge of the truth by the Administrator of Veterans' Affairs, and that neither

[1] It was, consequently, unnecessary for the court to determine whether the facts were otherwise sufficient to support the alleged estoppel or whether, if all the elements of estoppel existed, the Government would be bound by neglect of duty of its agents. These questions are reserved for argument if certiorari should be granted.

the Administrator personally, nor any subordinate official authorized to act for him in respect to insurance matters, had such knowledge earlier than May 13, 1937, when the insured's application for insurance benefits was received (R. 57–58), i. e., 15 days prior to his death (Cf. Pet. 17–19).

But petitioner contends that under Section 5 of the World War Veterans Act, as amended July 3, 1930 (38 U. S. C., Sec. 426), the Administrator of Veterans' Affairs is chargeable with knowledge with respect to insurance of facts which were made known only to the Compensation Division with respect to compensation. She, consequently, asserts that the Veterans' Administration had knowledge of the alleged fraud at least as early as February 1933, when the insured filed his application for compensation (Pet. 19). We submit, however, that petitioner's contention is clearly untenable.

The Veterans' Administration was created by consolidation of a number of agencies previously administering laws relating to relief and other benefits to former members of the military and naval service, including the Bureau of Pensions, the National Home for Disabled Volunteer Soldiers, and the United States Veterans' Bureau (c. 863, sec. 1; 46 Stat. 1016). Under the World War Veterans' Act of June 7, 1924, the Veterans' Bureau was charged with the responsibility of ad-

ministering the laws pertaining to compensation and treatment of veterans (Title II), the laws relating to veterans' insurance (Title III), and the laws providing for vocational rehabilitation (Title IV) (c. 320, 43 Stat. 615–628).

The statute authorizing creation of the Veterans' Administration provided in part (Sec. 1, Act of July 3, 1930, c. 863, 46 Stat. 1016, 38 U. S. C. Sec. 11):

> (b) Under the direction of the President the Administrator of Veterans' Affairs shall have the power, by order or regulation, to consolidate, eliminate, or redistribute the functions of the bureaus, agencies, offices, or activities in the Veterans' Administration and to create new ones therein, and, by rules and regulations not inconsistent with law, shall fix the functions thereof and the duties and powers of their respective executive heads.

Section 5 of the World War Veterans' Act, as amended July 3, 1930 (38 U. S. C. Sec. 426), upon a portion of which petitioner relies (Pet. 18), provides that the Administrator shall administer, execute, and enforce the provisions of the Act, make rules and regulations to carry out the purposes of it, decide all questions arising under it, and, further, that:

> All officers and employees of the Veterans' Administration shall perform such duties as may be assigned them by the Administrator. All official acts performed

> by such officers or employees specially designated therefor by the Administrator shall have the same force and effect as though performed by the Administrator in person. * * * The Administrator shall adopt reasonable and proper rules to govern the procedure of the divisions and to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits of compensation, insurance, vocational training, or maintenance and support allowance provided for in this Act, the forms of application of those claiming to be entitled to such benefits, the methods of making investigations and medical examinations, and the manner and form of adjudications and awards: * * *.

Since this statute prevents the act of any subordinate official within the Veterans' Administration being regarded as the act of the Administrator, unless such act be taken in the course of the performance of duties assigned to him by the Administrator, the acts of the officials designated to administer the compensation provisions of the statute are plainly not the acts of the Administrator regarding insurance. Consequently, the Circuit Court of Appeals properly held that the estoppel contention urged by the petitioner was without merit.

The same result was reached upon identical facts in *Jones* v. *United States,* 106 F. (2d) 888,

890–891 (C. C. A. 5), and the same conclusion was reached in *United States* v. *Riggins,* 65 F. (2d) 750 (C. C. A. 9), and *United States* v. *Depew,* 100 F. (2d) 725 (C. C. A. 10), upon facts differing only in that the truth was contained in the files of some other department of the Government instead of some other division of the Veterans' Administration. See also *Ritter* v. *United States,* 28 F. (2d) 265, 267 (C. C. A. 3), cited by the petitioner (Pet. 18), holding that the acts of an official of the Bureau of Internal Revenue, not connected with performance of the duties assigned to him by the Commissioner, were not to be regarded as the acts of the Commissioner.

It follows, therefore, that knowledge of the fraud was not imputable to the proper officials of the Veterans' Administration until the insured filed his application for insurance benefits on May 13, 1937. There is, accordingly, no basis for petitioner's assumption that the Administration collected some $800 in premiums subsequent to its knowledge of the fraud (Pet. 21–22).[2]

---

[2] There is not here involved, of course, any question as to the return of premiums retained by the Administration after it had acquired knowledge of the fraud. Petitioner did not pray in this suit for the return of the premiums but merely sought recovery of the proceeds of the insurance (R. 2–4), and the Government was not required to tender the return of the premiums as a prerequisite to the assertion of its defense of fraud. See *Bavisotto* v. *United States,* 18 F. Supp. 355 (W. D. N. Y.), citing numerous authorities.

(b) In her reasons for the allowance of the writ (Pet. 10–13), petitioner asserts that the Circuit Court of Appeals decided that the Government is not bound by the same rules as private insurance companies with respect to insurance of the character here involved. It is obvious, however, from the opinion of the Circuit Court of Appeals, that no such question was decided, and we submit that the proper disposition of the case does not require any such decision.

II

Petitioner's attack upon the findings of the District Court consists solely of the contention that the court erred in finding that the insured, prior to his insurance application, had consulted a physician in regard to his health, and had been treated for disease of the kidneys or bladder. She takes the position (Pet. 10) that a casual discussion with a physician on two occasions ten years apart, and the examination by another physician, do not constitute consultation and treatment. She relies upon that portion of the evidence, and those inferences drawn from it, that are most favorable to her (Pet. 4–5, 23).

But the issues of fact were determined, of course, by the District Court as a trier of the facts, and its findings will be set aside only if they are clearly erroneous. Rule 52 (a) of the Federal Rules of Civil Procedure for the District Courts of the United States.

There is ample evidence, which the District Court was entitled to believe and accept as true, tending to show that insured's condition prior to his application for insurance was not of a trivial or temporary nature of the character referred to in the decisions cited by petitioner (Pet. 23–24); that the insured was well aware that he had a disease of the bladder, manifested by blood in his urine as early as 1929; that on two occasions, and at his request, Dr. Bowe examined him and prescribed treatment for him; that he sought and obtained a cystoscopic examination from Dr. Broman, who advised him that he was afflicted with a bladder condition which should be treated; and that the obvious symptom of this condition, blood in his urine, was apparent and well known to the insured at the time he applied for insurance in March 1931. The cause of bleeding, ascertained in September 1930, had not been removed, and the report of a medical examination shows its existence in June 1931. Also, as was said by the Circuit Court of Appeals, the insured's "clear recollection of all the consultations later when he desired to use them to support his claim for compensation negatives the idea of mere forgetfulness" (R. 99).

Under the decisions relied upon by petitioner (Pet. 23–24), misrepresentation with respect to a trivial and unimportant condition may be disregarded and, as previously stated, petitioner con-

tends that the misrepresentations of the insured were of such character. The same decisions recognize, however, that misrepresentations with respect to material matters may not be disregarded, and the finding of the District Court, upon abundant evidence to warrant such finding, that the misrepresentations were material, renders these cases authorities wholly opposed to petitioner's contentions.

CONCLUSION

The decision of the Circuit Court of Appeals is correct. It presents no question of general importance, and there is involved no conflict of decisions. We respectfully submit therefore that the petition for writ of certiorari should be denied.

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